EMPLOYEE: This report is for your information. Keep it for your records. Read important information about your rights on back.

Alaska Department of Labor and Workforce Development
Alaska Workers' Compensation Board
P.O. Box 25512, Juneau, Alaska 99802-5512

COMPENSATION REPORT

(FOR INJURY DATES JULY 1, 1988 & AFTER)

AWCB Case Number Only

1. Employee's Last Name First Name Initial	2. Insurer Claim Number	3. Injury Date
4. Address	5a. ❒ Single ❒ Married / 5b. No. of Dependents	6. Social Security Number — —
City State Zip Telephone	(AWCB use only)	7. Birthdate
8. Employer	9. Insurer/Adjusting Company	
10. Address	11. Address	
City State Zip Telephone	City State Zip Telephone	

12. COMPENSATION RATE—COMPLETE FOR INITIAL PAYMENT OR RATE CHANGE

Employee's wages were calculated: ❒ Documents received_____

❒ a. Weekly = $_____ gross weekly earnings at time of injury (attach wage documents).

❒ b. Monthly = $_____ x 12/52 = $_____ gross weekly earnings (attach wage documents).

❒ c. Yearly = earnings $_____ ÷ 52 = $_____ gross weekly earnings (attach wage documents).

❒ d. Day, hour, or output = most favorable 13 consecutive calendar weeks within the 52 calendar weeks immediately before the injury
$_____ ÷ 13 = $_____ gross weekly earnings (attach wage documents).

❒ e. Worked less than 13 calendar weeks immediately before injury = $_____ earnings ÷ 13 = $_____ gross weekly earnings (attach wage documents).

❒ f. Wages not fixed at time of injury, explain how earnings determined_____

g. Seasonal/Temporary: ❒ After 7/1/00 earnings for 12 months immediately preceding date of injury $_____ ÷ 50 = gross weekly earnings;
Seasonal/Temporary: ❒ Before 7/1/00 earnings for calendar year preceding date of injury $_____ ÷ 50 = gross weekly earnings;

❒ h. 2 employers or more, use applicable methods above:

❒ i. Minor, apprentice, or trainee.

❒ j. Volunteer policeman, etc.

❒ k. Offset: Social Security (#39) or 155(i) (#40)

❒ l. Paid $110 minimum, explain_____

❒ 13. Date of injury before 9/4/95—2 year gross earnings = $_____

❒ 14. Room, board or pension

15. ❒ a. Alaska TTD, PTD, death	b. Gross Earnings $	Gross Weekly Earnings – Tax & FICA x 80% = $	Weekly Rate*	Maximum or Minimum $
❒ c. Alaska TPD ❒ Offset 41K	d. Weekly TTD Rate $	– ($ Weekly Earning Capacity – Tax & FICA x 80% = $)	= $ Weekly Rate*	Maximum or Minimum $
❒ e. Out-of-state TTD, PTD or death	f. Alaska TTD Rate $	State Ratio x	COLA Weekly Rate % = $	Date left Alaska / /

16. ❒ a. INITIAL PAYMENT ❒ b. SIF PAYMENT ONLY ❒ c. TERMINATION ❒ d. SUSPENSION ❒ e. RATE CHANGE ❒ f. TYPE CHANGE
❒ g. RESUMPTION Knowledge Date: / / ❒ h. OTHER (Explain)

17. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
					$	$
					$	$
					$	$
					$	$
					$	$
					$	$
					$	$

(If additional space is needed, use chart on reverse.) TOTAL

18. Impairment Rating: _____% of $135,000 Whole Person (Prior to 7/1/2000) = $_____; After 7/1/2000, _____% of $177,000 Whole Person = _____.

19. ❒ Permanent impairment compensation was paid in a lump sum. (Enter amount in No. 17 and 18.)
❒ If permanent impairment benefits not paid in a lump sum, enter date Employee requested reemployment benefits. Date_____

20. a. Date Disability Began	b. First Payment Date	21. Date Disability Ended
/ /	/ /	/ /

22. **TURN OVER AND COMPLETE ITEM 22 ON REVERSE**

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NONPAYMENT

23. ❒ Returned to Work _____/_____/_____ ❒ At New Job ❒ At Same Job
Occupation _____
Weekly Pay Rate $

24. ❒ Released for Work Date _____/_____/_____ ❒ Regular Work ❒ Modified Work

25. ❒ Medical Stability 27. ❒ C.O.L.A. 29. ❒ Recomputation 31. ❒ Other

26. ❒ Compromise and Release 28. ❒ Controversion (Attach 07-6105) 30. ❒ Board Order

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board.

32. Name and Title of Person Submitting Report (Type or Print)	33. Signature	34. Date

35. Address (if different from No. 11) City State Zip Telephone

36. Employee's Name (Last, First, Middle Initial) 37. Report Date

22. a. Employee Attorney Fees $ _____ b. Late Report Penalties $ _____ c. Employer Attorney Fees $ _____

d. Medical $ _____ e. Second Injury Fund $ _____ f. Reemployment Plan Cost $ _____

g. Reemployment $ _____ ❒ SIF Check Attached h. Interest $ _____

i. Other (explain) _____ $ _____

38. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
					$	$
					$	$
					$	$
					$	$
					$	$
					FRONT PAGE TOTAL	$
					TOTAL	$

39. SOCIAL SECURITY OFFSET. (Applies only to some recipients of Social Security Benefits.)

a. Social Security Retirement or Survivors Benefits (AS 23.30.225(a)). How the reduced weekly compensation was figured:

(1) SS Monthly Benefit SS Weekly Benefit Reduction (2) Weekly Rate Reduction Reduced Weekly Rate

$ x12/52 = $ x1/2 = $ $ – $ = $

b. Social Security Disability Benefits (AS 23.30.225(b)). How the reduced weekly compensation rate was figured:

(1) SS Monthly Benefit SS Wkly. Benefit (2) Gross Wkly. Earnings Max. Wkly. Pmt. SS Wkly. Benefit Reduced Wkly. Rate

$ x12/52 = $ $ x80% = $ – $ = $

40. Remarks

41. EXPLANATIONS AND ABBREVIATIONS

a. **Suspension**, Item 16d. means the employer/insurer has stopped compensation payments expecting to pay more compensation later (usually the difference between the minimum and the documented rate). See paragraph 42a. below for effect on medical benefits.

b. **Termination**, Item 16c. means the employer/insurer has stopped compensation payments with the belief all compensation due has been paid. See paragraph 40a. below, for effect on medical benefits.

c. In Item 17b., the following abbreviations means the following types of disability:

Dth = Death Benefits (Attach 07-6118)
25% = 25% Late Payment Penalty
TTD = Temporary Total Disability
TPD = Temporary Partial Disability
PPI = Permanent Partial Impairment
PTD = Permanent Total Disability
41K = Reemployment

d. **Knowledge Date** under Item 16g. means the date the employer/insurer learned about the employee's resumed disability or PPI rating.

e. **SIF** in Items 16b. and 22e. means Second Injury Fund. The insurer/employer makes this payment directly to the Alaska SIF, not the employee. SIF payments must be attached to the Board's annual report. The SIF payment does not affect the amount of compensation an employee receives.

42. TO EMPLOYEE (or other claimants in the case of death): READ CAREFULLY

a. This report means the insurer/employer has begun, stopped or changed your compensation payments. The insurer/employer should continue to pay for medical treatment for your injury for at least two years after your injury date. Although the law lets the insurer/employer stop medical payments two years after your injury date, you may file a written claim asking the Alaska Workers' Compensation (AWC) Board to authorize additional medical payments for treatment necessary to your recovery.

b. **YOU HAVE TWO YEARS FROM THE DATE OF THE COMPENSATION PAYMENT TO FILE A WRITTEN CLAIM FOR ADDITIONAL COMPENSATION PAYMENTS.**

c. If the AWC Board has issued a decision regarding your claim, you have one year from the date of the Board's order to file a written claim for a modification because of a change of condition or a mistake. If you have settled your claim by a compromise and release agreement which was approved by the AWC Board and later want to claim more benefits, contact the nearest AWC Board office for information. Attempts to get more benefits after an agreement seldom succeed.

d. IF YOU BELIEVE THIS REPORT CONTAINS MISTAKEN INFORMATION, IF PAYMENTS HAVE STOPPED AND YOU CANNOT WORK BECAUSE OF YOUR INJURY, OR IF YOU HAVE QUESTIONS, **CONTACT THE PERSON WHO SUBMITTED THE REPORT AT THE PHONE NUMBER OR ADDRESS GIVEN ON THE FRONT OF THIS REPORT**. IF YOU AND THAT PERSON CANNOT AGREE, OR IF YOU STILL HAVE QUESTIONS, CONTACT THE NEAREST AWC BOARD OFFICE. SEND COPIES OF YOUR WAGE DOCUMENTS TO THE INSURER/EMPLOYER: DO NOT SEND THEM TO THE AWC BOARD.

ALASKA WORKERS' COMPENSATION BOARD

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